2004 Federal Annual Report
Children's Health Insurance Program

California

Arnold Schwarzenegger, Governor
STATE OF CALIFORNIA
January 2005

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF
THE STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **California**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): Healthy Families/ Medi-Cal for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
X Combination of the above

Reporting Period: ***Federal Fiscal Year 2004*** *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

Contact Person/Title: **Carolyn Tagupa, Research Program Specialist II**

Address: **1000 G Street, Suite 450 Sacramento, CA 95814**

Phone: **(916) 324-4695** Fax: **(916) 327-9661**

Email: **ctagupa@mrmib.ca.gov**

Submission Date:

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
Eligibility						**From**	N/A	% of FPL conception to birth	N/A	% of FPL
	From	N/A	% of FPL for **infants**	N/A	% of FPL	**From**	200%	% of FPL for **infants**	250%	% of FPL
	From	N/A	% of FPL for children ages **1 through 5**	N/A	% of FPL	**From**	134%	% of FPL for **1 through 5**	250%	% of FPL
	From	N/A	% of FPL for children ages **6 through 16**	N/A	% of FPL	**From**	100%	% of FPL for children ages **6 through 16**	250%	% of FPL
	From	N/A	% of FPL for children ages **17 and 18**	N/A	% of FPL	**From**	100%	% of FPL for children ages **17 and 18**	250%	% of FPL

Is presumptive eligibility provided for children?		No		No
	X	Yes, for whom and how long? Beginning 7/1/03, children under 200% receiving services from a CHDP provider will be enrolled in no-cost Medicaid via the CHDP Gateway for two months.	X	Yes, for whom and how long? Beginning 7/1/03, children over 200% receiving services from a CHDP provider will be enrolled in SCHIP via the CHDP Gateway for two months.

Is retroactive eligibility available?		No	**X**	No
	X	Yes, for whom and how long? Yes, for children for up to 3 months.		Yes, for whom and how long? **[1000]**

Does your State Plan contain authority to implement a waiting list?	Not applicable			No
			X	Yes, however, under subsequent parental waiver (not yet implemented), California stated that no wait list will be used if parental waiver is implemented.
Does your program have a mail-in application?		No		No
	X	Yes	**X**	Yes

Can an applicant apply for your program over the phone?		No		No
	X	Yes	X	Yes

Does your program have an application on your website that can be printed, completed and mailed in?		No		No
	X	Yes	X	Yes

Can an applicant apply for your program on-line?		No		No	
	Yes – please check all that apply Yes, through a Certified Application Assistant			Yes – please check all that apply Yes, through a Certified Application Assistant	
	X	Signature page must be printed and mailed in		X	Signature page must be printed and mailed in
	X	Family documentation must be mailed (i.e., income documentation)		X	Family documentation must be mailed (i.e., income documentation)
	X	Electronic signature is required		X	Electronic signature is required
					No Signature is required

Does your program require a face-to-face interview during initial application	X	No	X	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	X	No		No
		Yes Note: this option requires an 1115 waiver Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6	X	Yes, if Employer Sponsored Insurance. Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6
	Specify number of months		Specify number of months	3 months

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
	X	Yes	X	Yes
	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	Death of the child, leave the State, applicant's request.		Reach age 19, non-payment of premium, death of the child, leave the State, and applicant's request.	

Does your program require premiums or an enrollment fee?	X	No			No	
		Yes		X	Yes	
	Enrollment fee amount			Enrollment fee amount		$0
	Premium amount			Premium amount		$4 to $9 per month per child with a maximum of $27/month for a family.
	Yearly cap			Yearly cap		$0
	If yes, briefly explain fee structure in the box below			If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)		
	[500]			$4 to $9 per month per child per maximum of $27/month for a family. Applicant may pay three months and receive the fourth month free. If the applicant uses Electronic Funds Transfer, he/she receives a 25% discount.		

Does your program impose copayments or coinsurance?	X	No		No
		Yes	X	Yes (Preventive services have no copayment. Copayments for other services limited to $5)

Does your program impose deductibles?	X	No	X	No
		Yes		Yes

Does your program require an assets test?	X	No	X	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]		**[500]**	

Does your program require income disregards?		No		No
	X	Yes	X	Yes
			If Yes, please describe below	
	For infants under one year of age with income between 185% and 200%.		Income greater than 200% though 250%	

Is a preprinted renewal form sent prior to eligibility expiring?	X	No		No	
	Yes, we send out form to family with their information pre-completed and			Yes, we send out form to family with their information pre-completed and	
		We send out form to family with their information pre-completed and ask for confirmation		X	We send out form to family with their information pre-completed and ask for confirmation
		We send out form but do not require a response unless income or other circumstances have changed			We send out form but do not require a response unless income or other circumstances have changed

Comments on Responses in Table:

Eligibility:
Note that California also covers the following children: 1) children ages 14-16 in the Medicaid Expansion from 0 to 100% FPL, 2) children ages 1 through 6 from 134 to 250% FPL in the SCHIP program, and 3) children ages 7 through 16 from 100% through 250% FPL in the SCHIP program. 4) Effective 7/1/04, infants born to mothers enrolled in the California State funded AIM program are automatically enrolled in SCHIP through age 2 up to 300% FPL. If the child's income is below 300% of FPL, the child will remain eligible. Prior to the third birthday, another annual determination will be made. The child will remain in SCHIP if the income is at or less than 250% FPL. 5) County/SCHIP funded Child Expansion up to 300% FPL in four counties. These categories were not listed in the SARTS template.

2.	Is there an assets test in your Medicaid Program?	☐	Yes	☒	No
3.	Is it different from the assets test in your separate child health program?	☐	Yes	☒	No
4.	Are there income disregards for your Medicaid program?	☒	Yes	☐	No
5.	Are they different from the income disregards in your separate child health program?	☐	Yes	☒	No
6.	Is a joint application used for your Medicaid and separate child health program?	☒	Yes	☐	No

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		X		X
b) Application		X		X
c) Benefit structure		X		X
d) Cost sharing (including amounts, populations, & collection process)		X		X
e) Crowd out policies		X		X
f) Delivery system		X		X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)		X		X
h) Eligibility levels / target population		X	X	
i) Assets test in Medicaid and/or SCHIP		X		X
j) Income disregards in Medicaid and/or SCHIP		X		X
k) Eligibility redetermination process		X		X
l) Enrollment process for health plan selection		X		X
m) Family coverage		X		X
n) Outreach (e.g., decrease funds, target outreach)		X		X
o) Premium assistance		X		X

p) Prenatal Eligibility expansion		X		X
q) Waiver populations (funded under title XXI)		X		X
Parents		X		X
Pregnant women		X		X
Childless adults		X		X

r) Other – please specify

a. **[50]**				
b. **[50]**				
c. **[50]**				

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	

h) Eligibility levels / target population	1. Effective 7/1/04, infants born to mothers enrolled in the Californian State funded AIM program are automatically enrolled in SCHIP through age 2 up to 300% FPL. At the time of the child's first birthday, eligibility is redetermined. If the child's income is below 300% of FPL, the child will remain eligible. Prior to the third birthday, another annual determination will be made. The child will remain in SCHIP if the income is at or less than 250% FPL. 2. County/SCHIP funded Child Expansion up to 300% FPL in four counties. 3. Both changes reflect eligibility expansion up to 300% FPL for specified children.
i) Assets test in Medicaid and/or SCHIP	
j) Income disregards in Medicaid and/or SCHIP	
k) Eligibility redetermination process	
l) Enrollment process for health plan selection	
m) Family coverage	
n) Outreach	
o) Premium assistance	
p) Prenatal Eligibility Expansion	
q) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
r) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: **X** Other Explain: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in 2005-2008 will be required to report this measurement.	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: □ Population not covered **X** Data not available Explain: Will be available March 2005 □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	**X** HEDIS Specify version of HEDIS used: HEDIS 2004 □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:**[7500]**	Data Source(s): Data is collected by MRMIB from participating Healthy Families Program (HFP) health plans and independently audited. Definition of Population Included in Measure: HFP members who were three, four, five or six years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. Baseline / Year: MRMIB has collected HEDIS data continuously since 2001. (Specify numerator and denominator for rates) Numerator=Number of children meeting population definition who had a visit. Denominator=Total number of children in this age group. Performance Progress/Year: (Specify numerator and denominator for rates)) Based on preliminary findings, plans with high scores for this measure continue to have high scores. Other health plan scores are improving. Explanation of Progress: Information will be available March 2005. Other Comments on Measure:**[700]**
Use of appropriate medications for children with asthma Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: **X** Other Explain: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]**

Measure	Measurement Specification	Performance Measures and Progress
information when it was first requested by CMS. Health plans participating in 2005-2008 will be required to report this measurement.		Explanation of Progress:**[700]** Other Comments on Measure:**[700]**
Children's access to primary care practitioners Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	**X** HEDIS Specify version of HEDIS used: HEDIS 2004 □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: Other Explain:**[7500]**	Data Source(s): Data is collected by MRMIB from participating Healthy Families Program (HFP) health plans and independently audited. Definition of Population Included in Measure: HFP members, ages 12 months through 18 years Baseline / Year: MRMIB has collected HEDIS data continuously since 2001. (Specify numerator and denominator for rates) Numerator=Number of children meeting population definition who had a visit. Denominator=Total number of children meeting population definition. Performance Progress / Year: HEDIS 2004 Numerator=Number of children meeting population definition who had a visit. Denominator=Total number of children meeting population definition. Explanation of Progress: Based on preliminary findings, plans with low scores continue to improve. Some scores have been impacted by poor methods of collecting data. Plans with scores above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% change and an explanation has not already been provided. Other Comments on Measure: Summarized results will be available during March 2005.
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: **X** Population not covered	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]**

Measure	Measurement Specification	Performance Measures and Progress
□ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	Specify version of HEDIS used: □ Other Explain:**[7500]**	Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure: **[700]**
Adult access to preventive/ambulatory health services Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**
Adult Prenatal and postpartum care (prenatal visits): □ Coverage for pregnant women over age 19 through a demonstration **X** Coverage for unborn children through the SCHIP state plan **X** Coverage for pregnant women under age 19 through the SCHIP state plan Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain:**[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain:**[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Baseline / Year: (Specify numerator and denominator for rates)**[500]** Performance Progress/Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress:**[700]** Other Comments on Measure:**[700]**

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. **Please wait until you have an enrollment number from SEDS before you complete this response.**

Program	FFY 2003	FFY 2004	Percent change FFY 2003-2004
SCHIP Medicaid Expansion Program	32,920	35,976	9.28%
Separate Child Health Program	822,866	847,735	3.02%

   A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

      The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in coverage for low-income families (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Prevention Program (CHDP) Gateway, Express Lane application through the schools for children eligible for the National School Lunch Program, and accelerated enrollment for children through the Single Point of Entry (SPE). The increased enrollment in the Medi-Cal Expansion program appears to be attributable to the growth in applications for children only through the Gateway and SPE, since property information is not required for these applications. Seventy two percent of applications through the SPE requested coverage for children only. In order to improve enrollment in the One-Month Bridge Program, the Administration has proposed the implementation of Healthy Families Bridge performance standards for counties, starting in July 2005, to ensure that all children potentially eligible are referred to Healthy Families through the One Month-Bridge Program.

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	1,258	82.5	13.1	0.9
1997-1999	1,244	82.2	12.8	0.8
2000-2002	968	66.5	9.6	0.6
2001-2003	893	64.0	8.8	0.6
Percent change 1996-1998 vs. 2001-2003	-29.0%	NA	-32.6%	NA

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.**[7500]**

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	California Health Interview Survey (CHIS)
Reporting period (2 or more points in time)	2001 and 2003
Methodology	The baseline is calculated by using Medi-Cal and HFP enrollment data and the 2000 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Recent Trends, Future Prospects* and at the UCLA Centers website: www.healthpolicy.ucla.edu. The methodology used for estimating the baseline did not change.
Population	CHIS is a general population survey that examines health insurance coverage, as well as numerous other issues. It surveys households through random selection and does so in five languages.
Sample sizes	2001 Survey: 55,000 households with over samples of Asian Pacific Islanders and American Indian/Alaska Natives. This sample included 5,000-6,000 adolescents and 14,000 children by proxy. 2003: Survey: 40,000 households with 4,000 adolescents and 9,000 children by proxy. Over samples were done of Koreans and Vietnamese.
Number and/or rate for two or more points in time	Half of all children (50.8%) were covered throughout the year in 2003 by their parent's employment-based insurance, a drop of 4.3 percentage points from 2001. Another 29.3% were covered all year by Medi-Cal; or Healthy Families, a substantial increase of 5.2 percentage points from 2001. Increasing enrollment in Medi-Cal and Healthy Families reflects efforts and resources invested in outreach and enrollment by voluntary organizations, as well as local children's health insurance expansion programs. It also reflects the programs are established and there is increased retention by Medi-Cal related to continuous eligibility.

Statistical significance of results	Results are statistically valid. More than 1.1 million children under age 19 were uninsured for all or part of the year in 2003 - a significant drop from the 1.5 million who had no insurance in 2001. This represents 2.4 percentage points less than 2001. When uninsured is viewed as a point in time, the number of uninsured, but not enrolled in HFP and Medi-Cal has decreased significantly. Of the 997,000 children uninsured for the entire year of 2001, 301,000 were eligible for the SCHIP program and 355,000 for Medi-Cal. Of the 782,000 children uninsured for the entire year in 2003, 224,000 were eligible for the SCHIP program and 207,000 for Medi-Cal.

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

California uses the California Health Interview Survey (CHIS) as its primary source of data for the number of uninsured. This data has a significantly larger sample size than CPS and also estimates whether children would have been eligible for SCHIP or Medi-Cal.

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

The CHIS is considered to be more precise than CPS data. Please refer to the CHIS fact sheet, Attachment I.

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification played a major role in Medi-Cal's continuing increase in enrollment. As mentioned in last year's report, the State funding for outreach was stopped in June of 2003. However, outreach still exists at the local levels for a wide variety of Children's Expansion Programs. For many of these programs (e.g., the Healthy Kids Programs) outreach and enrollment is privately funded through Foundations and Local First 5 Commissions. In those counties with Children's Expansion Programs, there have been positive impacts on both the Medi-Cal for Children and SCHIP Programs in California.

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Reducing the Number of Uninsured Children ***(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)***		
□ New/revised **X** Continuing □ Discontinued Explain: 1. Increase Awareness	Goal #1: Increase The Percentage Of Medi-Cal Eligible Children Who Are Enrolled In The Medi-Cal Program.	Data Source(s): California Department of Health Services Definition of Population Included in Measure:**[700]** Methodology: Analyze changes in number of eligible children in Medicaid in FFY 2003 and 2004. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**

<table>
<tr><th>(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)</th><th>(2) Performance Goals for each Strategic Objective</th><th>(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)</th></tr>
<tr><td></td><td></td><td>Explanation of Progress:
There has been an overall increase of 102,442 in the total number of children in Medi-Cal between June 2003 and June 2004. In the Regular Medi-Cal program, the number of children enrolled increased by 74,194 from 3,104,276 to 3,178,470. In the Medi-Cal Expansion program, the number of children increased by 29,197 from 52,155 to 81,352. However, in the One-Month Bridge Program, the number of children enrolled decreased by 949 from 3,494 to 2,545.

Children Enrolled in Medi-Cal & One-Month Bridge:
<table><tr><th></th><th>June 2003</th><th>June 2004</th><th>Change</th><th>Percent Change</th></tr><tr><td>Total Medicaid:</td><td>3,159,925</td><td>3,262,367</td><td>102,442</td><td>3.24%</td></tr><tr><td>Regular Medicaid:</td><td>3,104,276</td><td>3,178,470</td><td>74,194</td><td>2.39%</td></tr><tr><td>Medicaid Expansion:</td><td>52,155</td><td>81,352</td><td>29,197</td><td>55.98%</td></tr><tr><td>One Month Bridge:</td><td>3,494</td><td>2,545</td><td>-949</td><td>-27.16%</td></tr></table>
Other Comments on Measure:
The increase in the number of children in the regular Medi-Cal program is due to continuing minor growth in coverage for low-income families (Section 1931(b) of the Social Security Act) and efforts to facilitate the Medi-Cal application process for children through the Child Health and Disability Prevention Program (CHDP) Gateway, Express Lane application through the schools for children eligible for the National School Lunch Program, and accelerated enrollment for children through the Single Point of Entry (SPE). The increased enrollment in the Medi-Cal Expansion program appears to be attributable to the growth in applications for children only through the Gateway and SPE, since property information is not required for these applications. Seventy two percent of applications through the SPE requested coverage for children only. In order to improve enrollment in the One-Month Bridge Program, the Administration has proposed the implementation of Healthy Families Bridge performance standards for counties, starting in July 2005, to ensure that all children potentially eligible are referred to Healthy Families through the One Month-Bridge Program.</td></tr>
<tr><td>□ New/revised
X Continuing
□ Discontinued
Explain:

1. Increase Awareness</td><td>Goal #2:

Reduce The Percentage Of Uninsured Children In Target Income Families That Have Family Income Above No-Cost Medi-Cal.</td><td>Data Source(s):
“The State of Health Insurance in California: Findings from the 2001 and 2003 California Health Interview Survey” (Brown, et. al, UCLA 2004).
Definition of Population Included in Measure:[700]

Methodology:
Analyze changes in number of eligible uninsured children between 2001 and 2003 who were eligible for Medi-Cal or Healthy Families Program.</td></tr>
</table>

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Baseline / Year: 2001 (Specify numerator and denominator for rates) Denominator=Number of children eligible for but not enrolled in HFP in 2001. D = 301,000 Numerator=Number of children eligible for but, unenrolled in HFP in 2003. N = 224,000 Performance Progress / Year: (Specify numerator and denominator for rates) Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal: P = N/D = 25%. Explanation of Progress: **[700]** Other Comments on Measure:
□ New/revised □ Continuing **X** Discontinued Explain: 1. Increase Awareness	Goal #3: Reduce The Percentage Of Children Using The Emergency Room As Their Usual Source Of Primary Care.	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: **[700]** Other Comments on Measure: Program does not currently encounter data. Therefore, cannot determine if ER Utilization is excessive.

Objectives Related to SCHIP Enrollment

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing □ Discontinued Explain: 2. Provide An Application And Enrollment Process Which Is Easy To Understand And Use.	Goal #1: Ensure Medi-Cal And HFP Enrollment Contractor Provide Written And Telephone Services Spoken By Target Population.	Data Source(s): Enrollment Contractors/Enrollment Entities Definition of Population Included in Measure:**[700]** Methodology: Review and survey of current materials. Baseline / Year: (Specify numerator and denominator for rates) **[500]**

		Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: **[700]** Other Comments on Measure: Applicants can receive enrollment instructions, applications, and handbooks in ten languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Armenian, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices, and other program notification materials available in five languages: English, Spanish, Chinese, Korean, and Vietnamese. The program's administrative vendor maintains toll-free lines to provide pre- and post-enrollment assistance. These lines operate Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The toll-free HFP information line (800-880-5305) and the Medi-Cal outreach line (888-747-1222) are staffed with enrollment specialists who can provide HFP and Medi-Cal information, provide enrollment assistance, and give families information on the status of their application. The line is staffed by a team of operators proficient in the eleven designated languages in which campaign materials are published. In July 2001, a special toll free member services number (866-848-9166) was implemented to assist members with inquiries about and/or changes to their account, and provide members with information about eligibility appeals. The HFP member services call line operates Monday through Friday between 8:00 a.m. to 8:00 p.m. and on Saturday between 8:00 a.m. to 5:00 p.m.
□ New/revised **X**□ Continuing □ Discontinued Explain: 3. Ensure That Financial Barriers Do Not Keep Families From Enrolling Their Children.	Goal #1: Limit Program Costs To Two Percent Of Annual Household Income.	Data Source(s): Internal Enrollment Data, program design data, survey data. Definition of Population Included in Measure:**[700]** Methodology: **[500]** Review and analysis. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**

		Explanation of Progress: California continues to limit HFP costs to two percent of annual household income. With the limit of $250 for annual health benefit co-payments, based on the payment formula; it is mathematically impossible for subscribers to exceed the 5% income cap for families with incomes above 150%. Nor does HFP exceed the dollar amounts specified for families with incomes below 150%. The following table illustrates that the maximum cost sharing for a family at 150% of FPL falls well within the 5% annual cap. Other Comments on Measure: **[700]**

Children	Annual Income of a Single Parent	Maximum Annual Premium Contribution	Maximum Yearly Family Contribution (Premiums+$250 in Copays)	5% Contribution of a Family at 150% FPL
1	$15,915	$108	$358	$795
2	$19,995	$216	$466	$995
3+	$24,075	$324	$574	$1,203

From the State Evaluation for the Children's Health Insurance Program, March 2000

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 4. Ensure the Participation of Community Based Organizations In Outreach/Education Activities.	Goal #1: Ensure That A Variety Of Entities Experienced In Working With Target Populations Are Eligible For An Application Assistance Fee. Goal #2 Ensure that a variety of entities experienced in working with target populations and have subcontracts have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Source(s): MRMIB/DHS financial records Outreach and Education Contracts/Enrolled Entity Survey Definition of Population Included in Measure:**[700]** Methodology: Summary of expenses for application assistance from State FY 03/04. Review contract listing. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Explanation of Progress: As reported in previous years, Community Based Organizations (CBOs) continue to be an integral part of the outreach efforts throughout California. The Managed Risk Medical Insurance Board (MRMIB) continues to work and meet with CBOs, stakeholders and advocates on a quarterly basis to coordinate and maximize the resources and efforts at the local level. However, in June 2003 reimbursement to Certified Application Assistance (CAAs), who assist families to complete their applications, was eliminated. The loss of these funds continues to reduce the number of CBOs who participate in this outreach and enrollment activity. The role of the CAA was a very successful outreach effort for California. At the end of the 2003 FAR reporting period, the percentage of applications assisted by CAAs was consistently around 75%. This level of participation resulted in more complete applications being received at Single Point of Entry (SPE) that could be forwarded to the respective programs without delays, usually associated with incomplete applications. A complete application ensures much quicker access to medical services through the Medi-Cal and Healthy Families Program. At of the end of the 2004 FAR reporting period, the percentage of applications submitted with assistance from a CAA decreased to less than 15%. The number of incomplete applications has been a significant challenge for the State and the administrative vendor to find new and improved ways of requesting and processing additional information necessary to complete the application and the eligibility determination process. The Governor's 2005/2006 budget proposes to resume CAA reimbursement. MRMIB expects this resumption of funding will have a positive impact on outreach efforts through CBOs and the CAAs affiliated with those organizations. In response to the anticipated demands to certify persons interested in becoming a CAA, California implemented a Web Based Training curriculum on February 1, 2005. This on-line curriculum provides instruction, tests and certifies successful participants to assist families with their applications. It also provides links to valuable resources (e.g., Healthy Families website) and the web based electronic application (e.g. Health-e-App). This web based training is available 24 hours a day, seven days per week and can accommodate over 1,000 users at any one time. This curriculum will eliminate most of the need for face-to-face training, expect for isolated areas that may not be accessible to the internet. In the event face-to-face training is required, California continues to rely on the support and resources of the Master Trainers, to fill these training needs and/or gaps. Master Trainers are individuals who represent various CBOs throughout the state that have been state certified. During last year's reporting period, Master Trainers trained and certified over 200 CAAs. The state supports their efforts by providing training materials and certificates. These organizations and many more continue to support our mutual efforts through their own funding. Although the face-to-face training was phased out at the end of January 2005, California's training efforts through a contract with a private company was extremely successful. Between February 2004 and December 2004, over 1,300 CAAs were trained through this process. Each CAA represents a CBO and through their involvement California continues to include CBOs in our Outreach efforts. Other Comments on Measure: **[700]**
Objectives Related to Medicaid Enrollment		

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain:**[500]**	Goal #1:	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
□ New/revised **X** Continuing □ Discontinued Explain: 5. Provide A Choice Of Health Plans.	Goal #1: Provide each family with two or more health plan choices for their children. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): Enrollment data from the HFP Administrative Vendor - Electronic Data Systems (EDS). Definition of Population Included in Measure:**[700]** Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: HFP offers a broad range of health plans for program subscribers. A total of 27 health plans participated in the program during the reporting period. Over 99.72% of subscribers have a choice of at least two health plans from which to select. The 0.28% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. These subscribers are enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers. In 37 of 58 counties, subscribers have a choice of up to 3 or more health plans. In 4 of these 37 counties, members can choose from up to 7 health plans. Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised **X** Continuing, but restated □ Discontinued Explain: 6. Encourage The Inclusion Of Traditional And Safety Net Providers.	Goal #2: Ensure broad access in each county to Traditional and Safety Net providers for all Healthy Families Program members. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: X Other Explain: **[7500]**	Data Source(s): Data is collected by MRMIB from participating Healthy Families Program (HFP) health plans. Definition of Population Included in Measure: Traditional and Safety Net providers (clinics, CHDP providers and hospitals) in each county, as defined in Section 12693.21 of the Insurance Code. Methodology: As incentive to include traditional and safety net (T&SN) providers in their network, health plans with the highest T&SN participation in their county are allowed to offer the HFP product for a $3 per member per month discount. These plans are referred to as the Community Provider Plan (CPP). To determine which plans have the highest T&SN participation, health plans report which providers are in their network, from a list of providers supplied each year by MRMIB. In areas where the determination is close, health plans are required to supply documentation of contracts with providers reported to be in their network. The contracts are audited and the scores are recalculated, if any changes occur. Baseline / Year: (Specify numerator and denominator for rates) T&SN participation is re-evaluation each year, based on the previous year (July 1, 2003-June 30, 2004 for the 2005/2006 determination). Health plans with the highest score for T&SN participation in each county are announced at the annual March Board Meeting. Performance Progress / Year: (Specify numerator and denominator for rates) The percentage of members who can choose a CPP is 100%. The number of members choosing T&SN providers has consistently been greater than 60%. Numerator=Members established with T&SN provider. Denominator=Total HFP membership. Explanation of Progress: HFP participating health plans continue to include T&SN providers in their network and to participate in the competition for the one designated plan allowed to offer the HFP product at a discount. Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 7. Ensure That All Children With Significant Health Needs Receive Access To Appropriate Services.	Goal #1: Maintain or improve the percentage of children with services. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): HFP enrollment, CCS, and County mental health data. Definition of Population Included in Measure: Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) Explanation of Progress: Children enrolled in the HFP are referred to the California Children's Services (CCS) Program or county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. Reports submitted by participating plans indicated that 7,950 children were referred to the CCS program and that 1,538 children were referred to a county mental health program during the State fiscal year. The State has two administrative systems to facilitate the tracking of these children. The State continues to monitor access to services for children with special health care needs as it has since the inception of the program. Other Comments on Measure:
□ New/revised **X** Continuing □ Discontinued Explain: 7. Ensure That All Children With Significant Health Needs Receive Access To Appropriate Services.	Goal #2: Ensure no break in coverage as they access specialized services. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s):**[500]** Definition of Population Included in Measure:**[700]** Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]**

		Explanation of Progress: The State continues to monitor access to services for children with special health care needs as it has since the inception of the program. To ensure coordination of care for HFP subscribers who are eligible for the CCS and county mental health services, the Managed Risk Medical Insurance Board (MRMIB) developed a Memorandum of Understanding (MOU) for use by HFP participating plans and county CCS and mental programs. The MOU describes a common set of responsibilities for HFP participating plans and county CCS and mental health programs. Plans participating in the HFP are required to submit a MOU that has been signed by a plan official, a county CCS and a county mental official. MOUs are required in every county in which the plan serves the HFP. The State continues to monitor access to services for children with special health care needs as it has since the inception of the program. The State holds meetings with health, dental and vision plans and the CCS and county mental health programs as needed, and follows-up on complaints received from subscribers. The meetings with plans and the programs allow the State, the plans and the county programs to discuss problems they have with the MOUs, any arising or foreseeable barriers to access, and ways to eliminate these barriers. Newsletters were developed for county mental health programs to reinforce referral protocols for health plan/county mental health referrals and to provide county mental health departments with updates on the HFP. The California Institute of Mental Health in collaboration with the State developed these newsletters. During the reporting period, brochures were distributed to families to better educate them about the CCS and the county mental health programs. Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #1: Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	Data Source(s): Data is collected from HFP participating Health plans and independently audited. Definition of Population Included in Measure HFP members, ages 12 months through 18 years.

	X HEDIS Specify version of HEDIS used: 2004 Measure for Access: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Methodology: Plans report member level data to indicate if the member received a visit with a primary care physician during the measurement year. MRMIB calculates a percentage, then compares and reports this percentage each year. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can compare scores between health plans. Data is audited and certified. Plans provide summary data as well as member level data. MRMIB calculates percentages and compares the results with those submitted by the health plans. Plans are contacted for verification of any figures that do not agree. Baseline / Year: (Specify numerator and denominator for rates) MRMIB has collected HEDIS data continuously since 2001. Performance Progress / Year: (Specify numerator and denominator for rates) July 1, 2003 – June 30, 2004 Numerator=Number of children from population who had a visit during the measurement year. Denominator=Total number of children who met population criteria for this measure during the measurement year. Explanation of Progress: Based upon preliminary findings, plans with low scores continue to improve. Some scores have been impacted by poor methods of collecting data. Plans with scores above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% change and an explanation has not already been provided. Other Comments on Measure: The calculated percentage for this measure will be available and submitted in March 2005.
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #2: Achieve year-to-year improvements in the percentage of members three to six years old who received one or more well-child visits with a primary care practitioner during the measurement year.	Data Source(s): HEDIS 2004 Definition of Population Included in Measure: Three, four, five or six years of age that were continuously enrolled and who received one or more well-child visits with a primary care practitioner as of December 31st during the measurement year.

	X HEDIS Specify version of HEDIS used: 2004 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Measure □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Methodology: Plans report member level data to indicate if the member received a visit with a primary care physician during the measurement year. MRMIB calculates a percentage, then compares and reports this percentage each year. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can compare scores between health plans. Data is audited and certified. Plans provide summary data as well as member level data. MRMIB calculates percentages and compares the results with those submitted by the health plans. Plans are contacted for verification of any figures that do not agree. Baseline / Year: (Specify numerator and denominator for rates) MRMIB has collected HEDIS data continuously since 2001. Numerator=Number of children from population who had a visit during the measurement year. Denominator=Total number of children who met population criteria for this measure during the measurement year. Performance Progress / Year: (Specify numerator and denominator for rates) July 1, 2003 – June 30, 2004 Numerator=Number of children from population who had a visit during the measurement year. Denominator=Total number of children who met population criteria for this measure during the measurement year. Explanation of Progress: Based upon preliminary findings, plans with poor scores continue to improve. Some scores have been impacted by poor methods of collecting data. Plans with scores above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% change and an explanation has not already been provided. Other Comments on Measure: The calculated percentage for this measure will be available and submitted in March 2005.
□ New/revised **X** Continuing □ Discontinued Explain: 8. Ensure Health Services Purchases Are Accessible To Enrolled Children.	Goal #3: Achieve year-to-year improvements in the percentage of children who have received all recommended immunizations by age 2. **X** HEDIS Specify version of HEDIS used: 2004 Childhood Immunization Status	Data Source(s): Data is collected from HFP participating health plans. Definition of Population Included in Measure: HFP members who turn two years old during the measurement year with continuous enrollment twelve months prior to the child's second birthday. (Allowable gap: No more than one gap in enrollment of up to 45 days during the 12 months prior to their second birthday.)

	□ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Methodology: Plans report member level data to indicate if the member received each of six immunizations: DtaP/DT, OPV/IPV, MMR, HIB, Hepatitis B, and VZV. MRMIB uses this information to assign the Combination 1 and Combination 2 values. The Combination 2 value indicates the child received all of the vaccines listed and it is this value that is evaluated for the measure. MRMIB calculates a percentage, then compares and reports this percentage each year. This information becomes part of the HFP Handbook, provided to members at the time of open enrollment each year. Members can compare scores between health plans. Data is audited and certified. Plan provides summary data as well as member level data. MRMIB calculates percentages and compares the results with those submitted by the health plans. Plans are contacted for verification of any figures that do not agree. Baseline / Year: (Specify numerator and denominator for rates) MRMIB has collected HEDIS data continuously since 2001. Numerator=Number of children meeting the population criteria who received all six immunizations and therefore a score of one for Combination 2. Denominator=Total number of children meeting the population criteria. Performance Progress / Year: (Specify numerator and denominator for rates) July 1, 2003 – June 30, 2004 (Specify numerator and denominator for rates) Numerator=Number of children meeting the population criteria who received all six immunizations and therefore a score of one for Combination 2. Denominator=Total number of children meeting the population criteria. Explanation of Progress: Based on preliminary findings, plans with poor scores continue to improve. Plans with scores above 80% on HEDIS measures continue to have somewhat consistent high scores. Health plans are contacted for clarification if there is more than a 10% change and an explanation has not already been provided. Other Comments on Measure: Some scores have been impacted by poor methods of collecting data. For these plans, it is difficult to determine if more children are receiving immunization or if a similar number are receiving immunizations, but the immunization is being captured better. The calculated percentage for this measure will be available and submitted in March 2005.

Other Objectives		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised **X** Continuing □ Discontinued Explain: 9. Strengthen And Encourage Employer-Sponsored Coverage To Maximum Extent Possible.	Goal #1: Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: **X** Other Explain: **[7500]**	Data Source(s): Survey performed by the University of California, San Francisco (UCSF) August 2002. Definition of Population Included in Measure:**[700]** Methodology: Random sample of recent enrollees. Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates)**[7500]** Explanation of Progress: UCSF estimates crowd-out at 8%. Of this 8%, 75% indicated that they could not afford other insurance. These numbers indicate that crowd-out has not affected the HFP to any significant degree. Other Comments on Measure: **[700]**

1. WHAT OTHER STRATEGIES DOES YOUR STATE USE TO MEASURE AND REPORT ON ACCESS TO, QUALITY, OR OUTCOMES OF CARE RECEIVED BY YOUR SCHIP POPULATION? WHAT HAVE YOU FOUND?

MRMIB continues to obtain information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets: Fact Sheets are submitted by each health, dental and vision plan interested in participating in the HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports: Each year, health and dental plans are required to submit quality of care reports based on HEDIS® and a 120-day health (and dental) assessment measure. The HEDIS® reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. In examining data for the last three years, the HFP has consistently met or exceeded the scores for commercial and Medicaid plans in child-relevant HEDIS® measures.

California Children's Services (CCS) and Mental Health Referral Reports: The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. On a quarterly basis, plans are required to report the number of children referred to these services. The numbers reported by plans are compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services Report: This report allows staff to monitor how HFP subscribers' special needs related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

In prior years, participating plans were also required to provide a Group Needs Assessment Report. The report identified the unique perspectives of subscribers based on their cultural beliefs. It included an evaluation of community resources for providing health education and cultural and linguistic services, as well as an evaluation of the adequacy of the network for meeting community needs. This report is no longer required and will not be referenced in future Federal Annual Reports.

Member Surveys: MRMIB uses two types of member surveys, to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. For further information, please see Attachment II, Open Enrollment 2004 Survey Report.

Consumer satisfaction surveys, for both health and dental plans, are conducted each year. The surveys are conducted in five languages (English, Spanish, Chinese, Korean, and Vietnamese) and are based on the Consumer Assessment of Health Plans Survey (CAHPS ® 3.0H). Responses from the surveys provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health and dental plans and overall health and dental care. Significant findings for the program in the 2003 CAHPS ® 3.0H include:

- On a scale of 0-10 with "10" being the best care and "0" being the worst, at least 80 percent of families gave their health care, health plan, and personal doctor (or nurse) a rating of at least an 8.

- The aspect of care in which the highest percentage of families gave a high rating was in the overall rating of the health plan. Eighty-six percent of families rated their health plan an 8, 9 or 10.
- The percentage of families giving their personal doctor (or nurse) high ratings increased in 2003. In the 2003 survey, 82 percent of families gave their personal doctor (or nurse) a high rating; whereas in the 2002 survey, 80 percent of families gave their personal doctor (or nurse) a high rating.
- At least 86 percent of families responded positively when asked questions about how well their doctor communicates about getting needed care and about the courteousness and helpfulness of office staff.

For additional information, please see Attachment III, Healthy Families Program 2004 Report of Consumer Survey of Health Plans.

In September 2003, the MRMIB conducted the third Dental CAHPS ® Survey (D-CAHPS ® 2.0) to measure subscribers' experiences with dental care and to provide existing and potential HFP applicants with information about their dental plan options. Significant findings for the program in the D-CAHPS ® 2.0 include:

- Approximately 65, 67 and 70 percent of families gave their dental plan, dentist's care, and personal dentist, a rating of a t least an 8, respectively, on a scale of 0-10 with "10" being the best care.
- 71 percent of families responded positively when asked questions rating their dental specialist.
- 82 percent of families responded positively when asked questions about how well their dentist communicates.
- 82 percent responded positively when asked questions about the courteousness and helpfulness of office staff.

For additional information, please see Attachment IV, Healthy Families Program 2004 Report of Consumer Survey of Dental Plans.

Subscriber Complaints: MRMIB receives direct inquiries and complaints from HFP applicants. Approximately 90 percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

2. What **strategies** does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

HEDIS 2004 data are currently being summarized. These data are usually compiled by the end of the calendar year, but due to staffing shortages these data will not be available until March 2005. The data will be forwarded when it is available.

The State will be adding performance measures to new health and dental plan contracts that are scheduled for July 2005. In addition, the State has established the means to collect encounter/claims data from health and dental plans participating in the program. Based on recommendations from the HFP Quality Improvement Work Group, the focus of encounter/claims data collection will include emergency room admissions for asthma, diabetes-Type II, Attention Deficit Hyperactivity Disorder (ADHD) and depression treatment provided in the pediatrician's office and psychotropic medications, and appropriate treatment for children with upper respiratory infection (based on HEDIS®). This mechanism will be implemented when funding is provided.

In addition to new measures, the state will also explore the development of performance targets for preventive services and requirements for corrective actions when plans do not meet designated targets.

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

The Health Status Assessment Project was completed to evaluate the changes in health status of children newly enrolled in the HFP. The project examines the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance. The Project was conducted with financial support from the David and Lucile Packard Foundation. Under the project, MRMIB implemented a longitudinal survey of families of children who were newly enrolled in the HFP in 2001 to measure changes in access to care and health status among these children over two years of enrollment.

Results from this project showed:

- Dramatic, sustained improvements in health status for the children in the poorest health and significant, sustained increases for these children is paying attention in class and keeping up in school activities.
- Meaningful improvement in health status for the population at large.
- Increased access to care and reduced foregone health care for children in the poorest health and the population at large.
- A lack of significant variation by race and language in reports of no foregone care- the most significant variable associated with access.

The most significant improvements occurred after one year of enrollment in the program. These gains were sustained through the second year of enrollment. Because the survey does not quantify all factors that are attributable to changes in health status, it is not known how much of an impact changes in access to care has on the overall changes seen in health status. It is also not known what the underlying health status is of the children participating in this survey. Therefore, the conclusion that can be made regarding these results is that the HFP contributes to the improvements in health status by increasing access to health care services.

4. Please attach any **additional** studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

Attachment I: California Health Interview Survey

Attachment II: Open Enrollment 2004 Survey Report

Attachment III: Healthy Families Program 2004 Report of Consumer Survey of Health Plans

Attachment IV: Healthy Families Program 2004 Report of Consumer Survey of Dental Plans

Attachment V: 2002 Annual Retention Report

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., **[7500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

   As stated in last year's report, funding for CAA reimbursement ended on June 30, 2003. MRMIB continues to work with the David and Lucille Packard Foundation to sponsor the Connecting Kids Through Schools Project. The project focuses on school-based outreach and enrollment for the Healthy Families, and Medi-Cal, and County Children's Expansion Programs.

   The new administrative vendor (AV) for the Healthy Families Program (transitioned January 1, 2004) resumed CAA training throughout the state. A target of 1,500 new CAAs will be trained by the end of calendar year 2004. In addition, by June 30, 2004, the new AV re-assessed the interest of Enrollment Entities (EEs) to participate in the program. The number of interested EEs dropped from nearly 4,000 to 600 as a result of the loss of CAA reimbursement funding.

   MRMIB continues to convene a quarterly statewide outreach workgroup meeting focusing on coordination of local outreach activities. Information sharing, CBO partnering and networking are also facilitated.

2. What **methods** have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

   During last year's reporting period, over 85% of all applications were assisted by a CAA. As a result of the loss of CAA reimbursement, the number of applications assisted by a CAA has dramatically decreased to approximately 14.7%. Consequently, almost 78% of all applications being received by the Single Point of Entry are incomplete and require significant follow-up with the applicant to obtain missing information and enroll the child in the appropriate program.

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

   During the reporting period, fiscal challenges have prevented California from conducting State sponsored outreach. Past targeted outreach efforts have necessarily been discontinued.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted? Yes __X____ No _____

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted.

   2004: The HFP does not maintain any trigger mechanisms. The HFP precludes enrollment within three months of having had employer sponsored coverage.

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions? Yes ___X___ No _____

   If yes, identify your substitution prevention provisions (waiting periods, etc.).

   Under AB 495 SPA, four counties are authorized to serve otherwise eligible children with incomes between 250-300% FPL. These counties comply with three-month crowd-out provision.

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   2004: The manner in which the State monitors and measures substitution of coverage has not changed since the inception of the program in 1998. Crowd-out is monitored through the eligibility determination process and the collection of employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage.

   Children who received employer-based health coverage 90 days prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include:

   • The person or parent providing health coverage lost or changed jobs;

   • The family moved into an area where employer-sponsored coverage is not available;

   • The employer discontinued health benefits to all employees;

   • Coverage was lost because the individual providing the coverage died, legally separated, or divorced;

   • COBRA coverage ended; or

   • The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

4. At the time of application, what percent of applicants are found to have insurance?

   2004: The HFP does not currently collect data that would indicate the percentage of applicants that have insurance at the time of application. However, the HFP continues to exclude children from enrollment if they have had employer-sponsored health insurance in the last three months prior to their application, unless they meet one of five exceptions listed in question 1. Although the HFP tracks data related to employer-sponsored insurance during time of application, data is not currently available due to vendor transition.

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

   2004: Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of crowd-out occurring in the HFP. Their August 2002 study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of “crowd-out” was in the lower income group (below 200%) and that the single largest reason parents gave for dropping employer-sponsored coverage was that it was unaffordable. More than a quarter of the “crowd-out” group reported paying more than $75 per month.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

   The redetermination processes are similar; however, the redetermination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a redetermination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual redetermination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal the redetermination form is sent to SPE for HFP eligibility determination as long as there is parental consent. Failure to provide the completed annual redetermination form results in the discontinuance of benefits. However, should the beneficiary complete the annual redetermination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage. Note: This process has not change since the 2002 reporting period.

   In the SCHIP program, the applicant is mailed a custom pre-printed Annual Eligibility Review (AER) package 60 days prior to their children's anniversary date. The AER package also has an attached Add A Person form which is used to apply for any children who may now be in the home and wish to apply for both SCHIP and/or Medicaid. If the AER package has not been returned within 30 days, the applicant is contact by telephone to confirm receipt of the AER package, offer assistance to complete the package or to provide a referral to a local agency that can provide direct assistance to complete the AER package. If the package is not received within 45 days, the applicant is sent a pending disenrollment letter and the reason for the disenrollment (e.g., no package returned, missing information requested not received, etc.). If the AER package is not received or is not completed by the end of the anniversary month, the children are disenrolled and the applicant is sent the appropriate disenrollment letter. All denial and disenrollment letters include a Program Review form to return to the program if the applicant disagrees with the adverse action

2. Please explain **the process that occurs when a child's eligibility status changes from** Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

   In Medi-Cal (California's Medicaid Program), if a subscriber is determined to be ineligible due to income (too high) at Annual Eligibility Review (AER), the application is forwarded to HFP (if the applicant has provided consent to forward the form to Medi-Cal). To improve the coordination between the two programs and ensure continuity of care, the State grants an additional one month of Medi-Cal continued coverage while the application is being processed for HFP eligibility.

   In the HFP (California's SCHIP), if a subscriber is determined ineligible due to income (too low) at AER and the applicant has provided consent to forward to Medi-Cal, the AER application is forwarded to the county welfare department (CWD) in the county of the child's residence for a Medicaid eligibility determination. In this case, coordination between the two programs and continuity of care is ensured by the State granting two additional months of HFP 'bridge coverage" while the application is being processed for Medi-Cal eligibility.

   As part of the HFP bridge, California uses a detailed transmittal sheet which accompanies each application it forwards to the CWD. This sheet provides detailed subscriber information such as, the income determination used to screen for no-cost Medi-Cal eligibility for each individual subscriber, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track HFP and Medi-Cal applications, enrollment, and eligibility status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to the Single Point of Entry with the application and with any subsequent documentation for a HFP determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

2004: Medi-Cal uses both managed care and fee-for-service providers, whereas HFP utilizes only managed care providers. There is a significant overlap in the managed care networks for HFP and for Medi-Cal.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

X Conducts follow-up with clients through caseworkers/outreach workers

X Sends renewal reminder notices to all families

X *How many notices are sent to the family prior to disenrolling the child from the program?*

The HFP conducts AER Courtesy Calls 10 days after the AER package is sent, sends the applicant a reminder post-card 30 days after the AER package is sent, a pending disenrollment letter at least 14 days prior to a disenrollment prior to the end of the anniversary month. The pending disenrollment letter is accompanied by a Continued Enrollment form which can be used to appeal the pending disenrollment. If the CE form is received prior to the disenrollment, coverage will continue until the appeal is adjudicated.

X *At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?)*

Subscribers receive an AER Courtesy call 15 days after the AER package was sent to the confirm receipt. A reminder post card is sent after 30 days if the package is not received.

_____ Sends targeted mailings to selected populations
Please specify population(s) (e.g., lower income eligibility groups) **[500]**

_____ Holds information campaigns

X Provides a simplified reenrollment process,
Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Custom pre-printed re-enrollment package in 10 languages.

_____ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment

Please describe:

_____ Other*, please explain*: **[500]**

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

Same as 2003 – Currently, the HFP does not have data measuring the effectiveness of measures taken to retain eligible children.

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

___**X** Yes

_____No

When was the monthly report or assessment last conducted? 2002

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments.

Our monthly reports on disenrollment are on the MRMIB website, (www.mrmib.ca.gov). Charts can be found on avoidable, as well, as unavoidable disenrollments. In addition, we conduct an annual retention report. The report will be done in April 2005, and will be forwarded to you. For the most recent report related to 2002, please refer to Attachment V.

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	Obtain other public or private coverage		Remain uninsured		Age-out		Move to new geographic area		Other	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
284,084	209	.001%	N/A	N/A	14,743	5%	N/A	N/A	269,132	95%

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information.

The HFP assesses and reports a wide variety of enrollment and disenrollment related information on the MRMIB website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reasons children disenroll from the HFP. These reasons include children who do not re-enroll at their AER, not eligible at AER, age out of the program (i.e., reach age 19), and those who obtain other insurance at AER. In addition, MRMIB conducts an annual Retention Report which details the reasons subscribers do not stay in the program. This report is also posted on the MRMIB website.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

   California continues to use two surveys of families to assess subscriber children who are disenrolled from the Program due to non-payment of premiums. The first is post card survey which is mailed to every applicant after their child(ren)'s disenrollment from the Program for non-payment of premiums. This survey includes question about premiums and the cost of the Program. The applicant is asked to indicate which of the following reason best describes the reason they did not pay their premium: 1) cannot afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

   The second survey is in conjunction with the non-payment courtesy call initiated by an HFP operator 10 days prior to disenrollment from the Program for non-payment of premium. During this call, the applicant is reminded that a premium payment is necessary in order to keep their child enrolled in the Program. If the applicant indicates they will not be making the payment, the HFP operator attempts to establish the reason why the applicant is not able to make the payment. These reasons include, "Cannot afford the premiums".

From responses to these surveys, the State has found that it is often the case that applicants that want to disenroll their child frequently quit paying their premium rather than providing the HFP with formal notice of disenrollment. Both of these surveys are on a voluntary basis. However, based on both surveys it appears that only a very small percentage of those applicants who do respond are disenrolling from the Program because they cannot afford the cost of the monthly premium.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

   The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, many services provided in the HFP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without copayment. Copayments are also not required for services provide to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found?

   The State has not changed cost sharing.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

   Yes _____ please answer questions below.

   No **_X_** skip to Section IV.

Children

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan (Incidentally)
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

____ Parents and Caretaker Relatives

____ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.) [7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period = Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2004**	**2005**	**2006**
Insurance payments			
Managed Care	950,098,988	1,146,463,251	1,407,055,371
per member/per month rate @ # of eligibles			
Fee for Service	85,491,339	221,858,750	261,641,538
Total Benefit Costs	1,035,590,327	1,368,322,001	1,668,696,910
(Offsetting beneficiary cost sharing payments)	(48,863,495)	(45,214,863)	(52,033,174)
Net Benefit Costs	$986,726,832	$1,323,107,138	$1,616,663,736

Administration Costs			
Personnel			
General Administration	52,655,108	61,696,696	62,222,786
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	2,341,443	4,113,550	12,928,300
Other **[500]**			
Health Services Initiatives			
Total Administration Costs	54,996,551	65,810,246	75,151,086
10% Administrative Cap (net benefit costs ÷ 9)	109,636,315	147,011,904	179,629,304

Federal Title XXI Share	661,557,375	877,742,800	1,073,229,134
State Share	380,166,008	511,174,584	618,585,688

TOTAL COSTS OF APPROVED SCHIP PLAN	104,172,3383	1,388,917,384	1,691,814,822

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- **X** County/local funds
- _____ Employer contributions
- _____ Foundation grants
- _____ Private donations
- _____ Tobacco settlement
- _____ Other (specify) **[500]**

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table. *Note: This reporting period (Federal Fiscal Year 2003 starts 10/1/02 and ends 9/30/03).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2004**	**2005**	**2006**	**2007**	**2008**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)* **[500]**					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   As did many states in the nation, California faced challenges during the reporting period related to the state's difficult fiscal condition. Staffing reductions and associated staff turnover due to burnout made managing the program more difficult. As previously mentioned, the funding for Outreach was dramatically reduced over the last few years, including reimbursement for application assistance which was eliminated in June 2003. During the time Outreach was funded, approximately 75% of the applications received at Single Point of Entry (SPE) were complete. This was primarily because of the assistance provided by Certified Application Assistants. Although the volume of applications remained fairly consistent after the elimination of Outreach funding, the quality and completeness of the applications received at the SPE has declined. Currently, the number of incomplete applications received at SPE is approximately 75%. This has meant that families have a more difficult time enrolling in the program.

   There continues to be strong support for coverage for children, both in the Administration and the Legislature. The Governor's budget for the current year first called for placing a cap on enrollment in HFP, but the Governor managed to find the resources to rescind the proposal before the budget was finalized.

2. During the reporting period, what has been the greatest challenge your program has experienced?

   Another major challenge was the transition to a new administrative vendor – the first change in vendor since the program began in 1998. California transitioned both the Healthy Families Program and Single Point of Entry to the new administrative vendor, Maximus, on January 1, 2004. This was a significant undertaking for MRMIB and the Department of Health Services and a huge challenge for Maximus which implemented a new system with new staff while maintaining enrollment of over 700,000 children. When HFP began in 1998, the vendor initiated new systems with new staff—but had only a few applications and a steady increase in the volume of applications. Maximus had to transfer the active records for nearly 700,000 subscribers and be fully operational on day one while tending to approximately 30,000 applications and 50,000 Annual Eligibility Review determinations per month. The increase in the number of incomplete applications described above further complicated the new vendor's task. The new system was fully operational on January 1, 2004, and virtually all transition issues have now been resolved.

3. During the reporting period, what accomplishments have been achieved in your program?

   Despite staffing reductions and reductions in outreach, California has not seen a reduction in enrollment in HFP, and actually has experienced an increase in coverage when enrollment in Medi-Cal for children is considered. This results from strong efforts by advocates, community based organizations, and health plans to sustain enrollment in the programs.

   The successful transition to our new administrative vendor was also a major accomplishment. The new vendor has contributed to California's ability to sustain enrollment as it has been able to increase the number of applications and enrollments processed each month.

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

   Effective July 1, 2005, the Healthy Families Program (HFP) will be increasing its premiums for families with income greater than 200% of the federal poverty level through 250% of the federal poverty levels. This is the first premium increase since the program opened in 1998. Premiums will increase from $9 to $15 with a maximum of $45 per family. Those families that choose the Community Provider Plan will increase from $6 to $12 with a maximum of $36 per family. With the increase, the relationship of premium/income will be restored to the same percentage of income it was when the program began.

Effective spring of 2005, the state will once again begin paying for application assistance. The Governor has proposed restoration of application assistance in his budget for 2005-6 and will introduce urgency legislation to allow for payment to begin in Spring 2005.

Other initiatives proposed in the Governor's budget to improve children's health coverage are:

- The Administration plans to update the joint MC/HDP application form for the first time in 5 years.
- $5.4 million in the current year and $4.9 million in the budget year to fund federally eligible children in county Healthy Kids programs.
- The Administration will establish bridge performance standards to ensure that when county welfare departments place a child who has lost Medi-Cal eligibility on the "bridge" to obtain HFP, the counties comply with requirements to forward applications to HFP.
- Increased staffing at MRMIB to address appeals backlogs, administrative vendor monitoring and fiscal accountability.

Additionally, the Administration's Medi-Cal Reform proposal calls for eligibility processing for MC applications submitted through the Single Point of Entry would be done centrally and then sent to counties for maintenance. Initial determinations will be made by the HFP vendor and certified by a government employee.

Attachments

Attachment I: California Health Interview Survey

Attachment II: Open Enrollment 2004 Survey Report.

Attachment III: Healthy Families Program 2004 Report of Consumer Survey of Health Plans

Attachment IV: Healthy Families Program 2004 Report of Consumer Survey of Dental Plans

Attachment V: 2002 Annual Retention Report